Chapter 4

HEALTH INSURANCE FOR THE AGED AND DISABLED

Amendments to the Social Security Act enacted in 1965 established a broad program of health insurance, known popularly as "Medicare," for people age 65 or older, including railroad workers and members of their families. The program has two main parts. Part A provides hospital insurance and related benefits financed through payroll taxes. Part B provides medical insurance benefits on a voluntary basis, with the cost shared by the participants and the Federal Government.

Persons covered by the railroad retirement system participate in the health insurance program on the same basis as those under the social security system.

ELIGIBILITY

All railroad retirement beneficiaries age 65 or over and other persons who are directly or potentially eligible for railroad retirement benefits are covered by the program. Coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly benefits based on total disability for at least 24 months. Disabled widow(er)s under 65, disabled surviving divorced spouses under 65, and disabled children may also be eligible.

Full Medicare coverage before age 65 on the basis of chronic kidney disease is also available to employee annuitants, employees who have not retired but meet certain minimum service requirements, spouses, and dependent children who suffer from chronic renal dis-

eases requiring hemodialysis or a kidney transplant. Coverage for chronic renal disease may begin with the third month after the month hemodialysis treatment begins, or earlier under certain conditions.

EXPLANATION OF HOSPITAL INSURANCE BENEFITS (Part A of Medicare)

The hospital insurance program is designed to help pay the bills when an insured person is hospitalized. The program also provides payments for required professional services in a skilled nursing facility (but not for custodial care) following a hospital stay, home health services, and hospice care.

Benefits Provided

Benefits under this program cover medically necessary care in hospitals and skilled nursing facilities, home health visits and hospice care.

There is a limit on how many days of hospital or skilled nursing care Medicare helps pay for in each "benefit period." A benefit period begins the first day a patient receives services in a hospital. It ends after a person has been out of a hospital or other facility primarily providing skilled care for 60 days in a row.

Benefits are ordinarily paid only for services received in the United States or Canada. Hospital insurance also covers hospital stays in Mexico under very limited conditions.

The services for which payment will be made under the hospital insurance plan include the following:

1. For the first 60 days in a benefit period, the cost of all covered inpatient hospital services except for a deductible. From the 61st through the 90th day, hospital insurance pays for all covered services except for a daily coinsurance amount. Hospital insurance helps pay for up to 90 days in a participating hospital in a benefit period. Additional days are available, up to a lifetime total of 60, after exhaustion of the 90 days; the patient pays a daily coinsurance

amount for these additional days. Covered hospital services include almost all those ordinarily furnished by a hospital to its patients. However, payments will not be made for private-duty nursing or personal comfort items.

2. Under certain conditions, the cost of skilled nursing care after a hospital stay in a facility approved by Medicare for services of a professional level (custodial care is not covered) for the first 20 days in each benefit period plus up to 80 additional days with the patient paying a daily coinsurance amount for the 21st through the 100th days.

3. Under certain conditions and if confined at home, the cost of medically necessary home health visits furnished by a participating home health agency. If the patient needs intermittent skilled nursing care, physical therapy or speech therapy, Medicare also pays for occupational therapy, part-time or intermittent services of home health aides, medical social services, medical supplies, and 80 percent of the approved amount of durable medical amount.

4. Under certain conditions, the cost of hospice care for terminally-ill patients. A hospice is a public agency or private organization primarily engaged in providing pain relief and supportive services to terminally ill people. Hospice coverage pays for up to 210 days, or even longer in some cases. During a hospice benefit period, Medicare pays the full cost of all covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care.

Financing

Railroad employers and employees each pay hospital insurance taxes with their railroad retirement taxes. These taxes are collected together with the regular retirement taxes and initially go into the railroad retirement trust funds. They are subsequently transferred to the Federal Hospital Insurance Trust Fund. The cost of hospital insurance benefits for social security and railroad retirement beneficiaries (other than the cost of benefits for the latter with respect to services received in Canada) is borne by that fund. The Railroad

Retirement Account bears the costs for compensable benefits paid to railroad retirement beneficiaries for services received in Canada.

EXPLANATION OF MEDICAL INSURANCE BENEFITS (Part B of Medicare)

The medical insurance program is designed to help pay the bills for doctors' services and for a number of other medical costs not covered by the hospital insurance program. The medical insurance program is voluntary, but eligible persons who wish to participate pay a monthly premium. For persons who are receiving railroad retirement benefits (including those also in receipt of social security benefits), the monthly premium is deducted from their railroad retirement checks; others make cash payments or, in some cases, have their premiums paid under a State assistance program.

Benefits Provided

Medicare medical insurance helps pay for doctors' services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, and X-rays.

Each year, before Medicare medical insurance begins paying for covered services, the annual medical insurance "deductible" must be met. After the deductible is met, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year.

Medicare provides basic protection against the high cost of illness, but it will not pay all health care expenses. Some of the services and supplies Medicare cannot pay for are: custodial care, such as help with bathing, eating, and taking medicine; dentures and routine dental care; most eyeglasses, hearing aids, and examinations to prescribe or fit them; long-term care (nursing homes); personal comfort items, such as a phone or TV in a hospital room; most prescription drugs and patent medicines; and routine physical checkups and related tests.

Medical insurance generally does not pay for services outside the United States. There are rare emergency cases where medical insurance can pay for care in Canada or Mexico. Medical insurance can sometimes also pay if a Canadian or Mexican hospital is closer to a beneficiary's home than the nearest U.S. hospital that can provide the care needed. If emergency treatment is received in a Canadian or Mexican hospital or if a beneficiary lives near a Canadian or Mexican hospital, he or she should ask the Board's carrier about coverage.

Persons planning to travel outside the United States may want to buy special short-term health insurance for foreign travel. If they have a health insurance policy that supplements Medicare (a Medigap policy), they should check to see if foreign travel is covered.

Financing

Part B medical insurance is paid for in part by premiums from persons who enroll in the program. The Federal Government subsidizes about 75 percent of the program costs.

HEALTH INSURANCE THROUGH AN EMPLOYER PLAN

Persons ages 65 and over who are working for an employer with 20 or more employees and workers' spouses ages 65 and over must, by law, be offered the same health benefits that are offered to younger workers. If an employee continues working after age 65, he or she has the option to reject the employer's health plan. If it is rejected, Medicare remains the primary health insurance payer and the employer plan cannot offer coverage supplementing Medicare.

Medicare is the secondary payer for certain disabled people who are covered under a large group health plan through their current employment or a health plan based on current employment of a family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people. The plan must not treat anyone differently because they are disabled and have Medicare.

ENROLLMENT

If a retired employee or a family member is receiving a railroad retirement annuity, enrollment for both hospital and medical insurance is generally automatic and begins when the person reaches age 65. Even though enrollment is automatic, an individual may decline medical insurance, if so desired; this does not preclude him or her from applying for medical insurance at a later date. Premiums may be higher if enrollment is delayed.

If an individual is eligible for but not receiving an annuity, he or she should contact the nearest Board office before attaining age 65 and apply for both hospital and medical insurance. (This does not mean that the individual must retire if presently working.) The best time to apply is during the three months before the month in which the individual reaches age 65. He or she will then have both hospital and medical protection beginning with the month age 65 is reached. If the individual is not enrolled for medical insurance in the three months before attaining age 65, he or she can be enrolled in the month age 65 is reached or during the next three months, but there would be a delay of one to three months before medical insurance becomes effective. Individuals who do not enroll during their initial enrollment period may sign up in any General Enrollment Period (January 1 - March 31 each year). Coverage for such individuals begins July 1 of the year of enrollment.

Premiums for medical insurance are increased 10 percent for each year the individual could have been, but was not, enrolled. However, when individuals are covered by an employer health plan based on their or their spouse's current employment, enrollment may be delayed without penalty and special enrollment periods may apply.

For information on enrollment before age 65 on the basis of disability, potential applicants should contact the nearest Board office. For information on coverage for kidney disease, a social security office should be contacted.

MANAGED CARE PLANS

Managed care plans (sometimes called HMOs) that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, services usually must be obtained from the plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases, for services not authorized by the plan (except emergency services or services urgently required while out of the plan's service area) neither the plan nor Medicare will pay for these services. If a patient enrolls in a managed care plan, he or she may have to pay a fixed monthly premium to the plan and small copayments with each visit to the doctor or use of other services. The patient must also continue to pay the Part B monthly Medicare premium.

Many managed care plans that have contracts with the Medicare program also provide benefits beyond those Medicare pays for. These include preventive care, such as checkups, scheduled inoculations, prescription drugs, hearing aids, and eye examinations for little or no extra fee. The benefits vary from plan to plan.

CLAIMING MEDICARE BENEFITS

When a patient receives hospital insurance benefits, he or she is billed by the hospital only for the deductible amount, any coinsurance amount and any noncovered services. The remainder of the bill from the hospital, as well as bills for services in skilled nursing facilities or home health visits, is sent to the intermediary selected to serve the area. However, the patient is given a record of what services were utilized for each claim.

Claims for medical insurance benefits filed on behalf of railroad retirement beneficiaries are generally handled by the Board's carrier on a nationwide basis.

Under the assignment method, the doctor or supplier agrees that his or her total charge for the covered service will be the amount approved by the Medicare carrier. Medicare pays the doctor or sup-

plier 80 percent of the approved amount, after subtracting any part of the $100 annual deductible the patient has not met. The doctor or supplier can charge the patient only for the part of the $100 annual deductible not met and for the coinsurance, which is the remaining 20 percent of the approved amount. The doctor or supplier also can charge for any services that Medicare does not cover.

If the doctor does not accept assignment, the patient must pay directly and is responsible for any part of the bill that is more than the Medicare-approved amount. Medicare pays the patient 80 percent of the approved amount, after subtracting any part of the annual deductible not met. Even if a doctor does not accept assignment, there are limits in the amount he or she can charge. All doctors and suppliers must fill out claim forms for patients and send them to Medicare whether or not they take assignment.

Doctors and suppliers can sign agreements to become Medicare-participating. This means that they have agreed in advance to accept assignment on all Medicare claims. The names and addresses of Medicare-participating doctors and suppliers are listed (by geographic area) in the "Medicare-Participating Physician/Supplier Directory." This directory is available for review in all Railroad Retirement Board and Social Security Administration offices, State and area offices of the Administration on Aging and most hospitals.

APPEALS

If a patient disagrees with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare, he or she has the right to appeal the decision. The notice received from Medicare stating the decision made on a claim also tells a patient exactly what appeal steps can be taken. More information about appeal rights can be obtained from any Railroad Retirement Board office.

RIGHT TO DECIDE ON MEDICAL CARE

Under Medicare law, when someone is admitted to a Medicare hospital or skilled nursing facility, gets Medicare home health care, or enrolls in a Medicare-certified hospice or health maintenance organization, the person must be given written information about the right to accept or refuse medical or surgical treatment. The person will also be told about the right to make an "advance directive." This directive contains written instructions stating the person's choices for health care or names someone to make those choices. The instructions are to be used if the person is too sick or otherwise unable to talk. The paper may be called a living will or durable power of attorney for health care. It is not necessary to have one of these papers. But if the person has one, he or she can say yes or no in advance regarding treatment. Laws governing advance directives vary from State to State.

BUYING HEALTH INSURANCE TO SUPPLEMENT MEDICARE (MEDIGAP)

Medicare provides basic protection against the high cost of health care, but it will not pay all medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare (Medigap insurance). A booklet, *Guide to Health Insurance for People with Medicare,* is available to help with Medicare supplement decisions. Medigap insurance is generally not needed if a managed care plan is used.

ADMINISTRATION OF MEDICARE

The Secretary of Health and Human Services, operating through the Health Care Financing Administration, is responsible for administering both parts of Medicare. Assistance in the administration is supplied by various public and private organizations. The physician is the key figure in determining utilization of health services. The physician decides on admission to a hospital, orders tests, drugs, and

treatments, and determines the length of stay. Payment to the provider is made only if a physician certifies the medical necessity of the services furnished in a skilled nursing facility or in the patient's home or the continued need of services in a general hospital. The choice of a physician is entirely up to the beneficiary.

Role of the U.S. Railroad Retirement Board

The Railroad Retirement Board has the same authority to determine the rights of persons coming under its jurisdiction as the Social Security Administration has with respect to its own beneficiaries. The Board establishes the eligibility for hospital insurance benefits of actual or potential railroad retirement beneficiaries and certifies the records of such individuals to the Secretary of Health and Human Services. It enrolls qualified railroad retirement beneficiaries in the medical insurance plan and collects Part B premiums. In addition, the Board has sole authority to select a carrier to handle medical insurance claims of all railroad beneficiaries. The carrier is the United HealthCare Corporation (formerly called The MetraHealth Companies, Inc.).